

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY

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E-mail: cbot@dca.ca.gov; Web: www.bot.ca.govState of California
Department of Consumer Affairs
Gray Davis, Governor**WORK/EXPERIENCE VERIFICATION FORM****Complete this form only if you are qualifying on the basis of current practice.****(Please Print or Type)****Section 1. Applicant: Complete the information in Section 1 for each occupational therapy employer, then forward the form to the employer/supervisor.**

Last Name	First Name	Middle Name	Social Security Number (Optional)
Employer's Name		Employer's Address (Street, City, State, Zip Code)	
Job Title:		Dates of Employment - From: To:	
Description of Job Duties (Attach additional pages if necessary):			Nature of Patients/Clientele:
Supervisor's Name		Supervisor's Job Title:	

*I certify under penalty of perjury of the laws of State of California that the information provided on this form is a true and accurate reflection of my work/experience with this employer.*_____
Signature of Applicant_____
Date

Applicant complete above
Supervisor/Employer complete below

Section 2. Supervisor/Employer: The above named individual indicates that he/she has recently practiced occupational therapy with your organization. Please complete, sign, date, and return this form directly to the Board.Is the information provided in Section 1, an accurate reflection of the applicant's work experience in this employment setting? ☐ Yes ☐ No

If no, on a separate attachment please explain any differences.

*I certify under penalty of perjury of the laws of the State of California that the information I am verifying is true and correct.*_____
Supervisor's/Employer's Name (please print)_____
Job Title_____
Signature of Employer/Supervisor_____
Date